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IN THE
Supreme Court of the United States

BOBBY JAMES MOORE,

Petitioner,

v.

TEXAS,

Respondent.

On Petition For A Writ Of Certiorari To The Texas Court Of Criminal Appeals

BRIEF FOR *AMICI CURIAE* THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, THE CONSTITUTION PROJECT, AND THE SOUTHERN CENTER FOR HUMAN RIGHTS IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

The American Academy of Psychiatry and the Law (AAPL), with approximately 1,500 psychiatrist members dedicated to excellence in practice, teaching, and research in forensic psychiatry, has participated as an *amicus curiae* in, among other cases, *Hall v. Florida*, 134 S. Ct. 1986 (2014); *Brown v. Plata*, 563 U.S. 493 (2011); *Indiana v. Edwards*, 554 U.S. 164 (2008); *Clark v. Arizona*, 548 U.S. 735 (2006); and *Penry v. Johnson*, 532 U.S. 782 (2001). AAPL's member physicians work to ensure accurate evaluation, humane care, and effective treatment for all persons with mental disorders, including intellectual disabilities. AAPL's members engage in treatment, research, and forensic activities, and many of them regularly perform roles in the criminal justice system.

The Constitution Project is a bipartisan nonprofit organization that seeks solutions to contemporary constitutional issues through scholarship and public education. Beginning in May 2001, the Project's Death Penalty Initiative convened a blue-ribbon committee including supporters and opponents of the death penalty, Democrats and Republicans, former judges, prosecutors, defense lawyers, victim advocates, and others, to examine issues related to the

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[1] Pursuant to Rule 37.2(a), counsel of record for all parties received timely notice of *amici*'s intent to file this brief. Counsel of record for all parties consented in writing to its filing.

No counsel for any party authored this brief in whole or in part, and no person or entity other than *amici curiae* or counsel made a monetary contribution to the preparation or submission of this brief.

administration of the death penalty. The committee's most recent report makes 39 recommendations that the committee believes are essential to reducing the risk of wrongful capital convictions and executions, including safeguarding the Eighth Amendment's prohibition against the execution of individuals with intellectual disability. See The Constitution Project, IRREVERSIBLE ERROR (2014).

The Southern Center for Human Rights (SCHR) is a nonprofit law office based in Atlanta, Georgia. For the past 40 years, SCHR has represented people facing the death penalty in the southern United States. In the 1980s, SCHR's advocacy contributed to Georgia becoming the first state in the nation to prohibit the practice of executing people with intellectual disability. This Court later held in *Atkins* that the practice violates the Eighth Amendment. SCHR is concerned that despite those developments, intellectually disabled people still are being sentenced to death and executed throughout the nation, in part because courts are relying on outdated understandings of intellectual disability.

SUMMARY OF ARGUMENT

In *Hall v. Florida*, 134 S. Ct. 1986 (2014), this Court invalidated Florida's *Atkins* procedures because they did not comply with modern diagnostic standards for intellectual disability.[2] Because society "relies upon medical and professional expertise to define and explain how to diagnose the mental condition at issue," in "determining who qualifies as intellectually disabled, it is proper to consult the medical community's opinions." *Id.* at 1993. Yet, as the petition correctly argues, the decision below creates a clear split in authority regarding whether a court may require the use of outdated diagnostic criteria when assessing *Atkins* claims, as Texas does. The answer to that question, which follows *a fortiori* from *Hall*, is equally clear: No.

Amici will not repeat those arguments here. Instead, the purpose of this filing is to explain why the resolution of that issue is of exceptional importance, such that this Court's review would be especially worthwhile. See Sup. Ct. R. 10. In short, the consensus diagnostic criteria for intellectual disability have changed in important ways over time, such that a refusal to consider up-to-date criteria will necessarily

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[2] In this brief, *amici* use the term "intellectual disability" to describe the phenomenon that *Atkins* referred to as "mental retardation," in keeping with the modern practice. See Rosa's Law, Pub. L. No. 111-256 § 2, 124 Stat. 2643 (2010) (changing entries in the U.S. Code from "mental retardation" to "intellectual disability"); *Hall*, 134 S. Ct., at 1990 ("This change in terminology is approved and used in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, one of the basic texts used by psychiatrists and other experts").

result in the execution of defendants who are plainly intellectually disabled under consensus standards. In the early 20th century, intellectual disability was generally diagnosed almost entirely through mechanical application of IQ tests. Since then, there has been a steady trend in the diagnostic criteria to (1) emphasize individualized clinical assessment of both intellectual ability and what is known as "adaptive functioning," and (2) deemphasize reliance on IQ scores, especially scores that are not corrected for factors like standard error in measurement and test norm obsolescence (which can causes older test scores to appear artificially higher).

That modern trend has culminated in the publication of the latest clinical definitions of intellectual disability. See American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) (hereinafter "DSM-5"); American Association on Intellectual & Developmental Disabilities, INTELLECTUAL DISABILITY: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS (11th ed. 2010) (hereinafter, "AAIDD Manual").[3] These clinical definitions—which this Court applied in *Hall* to invalidate Florida's scheme—require significant limitations in intellectual and adaptive functioning, as assessed by individualized clinical evaluation, as well as onset during the developmental period. See DSM-5 33; AAIDD Manual 27. While intelligence testing remains one tool to aid a clinician's assessment of intellectual functioning, IQ ranges are no longer part of

[3] Although there are certain technical differences in the APA and AAIDD clinical definitions, they are not implicated by the question presented.

the DSM-5 definition of intellectual disability. Moreover, standard error measurements and test norm obsolescence must be taken into account, and the severity of the disability is now defined by reference to adaptive functioning, rather than IQ scores.

The use of these modern standards will be a question of life or death in many cases—because there will be a number of individuals who might *not* meet the criteria for intellectual disability as expressed in certain now-outdated standards, but who *do* satisfy the accepted modern criteria. Because the answer to the question presented will be outcome-determinative in many death penalty cases, where the punishment "is qualitatively different from any other sentence," this Court's resolution of the split in authority identified by the petition is especially justified. *Lockett v. Ohio*, 438 U.S. 586, 604 (1978).

ARGUMENT

I. DIAGNOSTIC CRITERIA FOR INTELLECTUAL DISABILITY HAVE EVOLVED SUBSTANTIALLY OVER TIME

Anglo-American law has long recognized a relationship between intellectual capacity and criminal responsibility—and has, for just as long, recognized that our understanding of that relationship is constantly evolving. Blackstone observed that "ancient Saxon law" had provided that a child under twelve could not be "guilty in will" of a capital crime—but noted that under the law "as it now stands, and has stood at least ever since the time of Edward the third," the "capacity of doing ill ... is not so much measured by years and days, as by the strength of the delinquent's understanding and judgment." 4 W. Black-

stone, COMMENTARIES ON THE LAWS OF ENGLAND 24 (1765). Blackstone's conception of intellectual disability (which was essentially restricted to those he deemed "idiots") was, thankfully, not the terminus of our society's understanding—though even then, it was coming to be understood that the question of intellectual capacity could not be answered by simplistic numerical lines alone.

Just as it would have been wrong to freeze the Saxon practice in place as our law's unyielding yardstick of intellectual disability, there is no justification for allowing States to apply outdated clinical standards (insofar as they conflict with current ones). If States are not required to use the current diagnostic standards, then there is no particular reason that they may not use *any* obsolete standard, such as the discarded standards of the DSM-III (from 1980) or the DSM-II (from 1968)—or, for that matter, Blackstone's standards.

Surveying the history of change in the criteria for diagnosis of intellectual disability illustrates why it is exceptionally important that modern standards be required. The history of diagnosing intellectual disability is a history of refinements and improvements to produce more accurate and reliable diagnoses. And those changes tell a consistent story: toward individualized clinical evaluation of intelligence, toward emphasis on adaptive functioning, and away from mechanical reliance on IQ scores—especially scores uncorrected for standard measurement error and norm obsolescence. "To enforce the Constitution's protection of human dignity, this Court looks to the evolving standards of decency that mark the progress of a maturing society." *Hall*, 134 S. Ct., at 1992 (quoting

Trop v. Dulles, 356 U.S. 86, 101 (1958)). Modern standards for intellectual disability are part of that "progress of a maturing society"—and the Eighth Amendment requires States to use them.

A. Pre-*Atkins* Criteria for Diagnosis of Intellectual Disability

In the 20th century, the advent of universal public education also created a need to identify children who were likely to need special assistance in school, leading two French educational psychologists to develop an early intelligence test for this purpose—the Binet-Simon Intelligence Scale. See THE OXFORD COMPANION TO THE MIND 88 (O.L. Zangwill & Richard L. Gregory eds., 1987). In an effort to simplify the results of the Binet-Simon test, German psychologist William Stern created the now well-known "intelligence quotient"—IQ—which was designed to express a ratio between the child's ability and the norm for the child's age, multiplied by 100 for ease of reading. See generally William Stern, THE PSYCHOLOGICAL METHODS OF TESTING INTELLIGENCE (1914) (Guy Montrose Whipple, trans.).

The IQ test proved popular, not least because its simple numerical output proved easy to use in bureaucracies. And in the United States, the Binet-Simon test was translated and imported by eugenicists who immediately advocated for its use in (for example) "placing people with mild [intellectual disability] into gender-segregated large institutions" and "adoption of enforced sterilization laws." Haydt, Greenspan & Argharkar, *Advantages of DSM-5 in the Diagnosis of Intellectual Disability: Reduced Reliance on IQ Ceilings in* Atkins *(Death Penalty) Cases*, 82

U.M.K.C. L. Rev. 359, 363 (2014). At this early stage, intellectual disability was often "defined and diagnosed entirely based on IQ scores." *Ibid.*

But "dissatisfaction with the IQ score as the sole indicator of [intellectual disability] emerged over time." AAIDD Manual 43. And there were also "concerns about racial and socioeconomic discrimination," including worries that "excessive numbers of poor minority children" were being "wrongly assigned the [intellectual disability] label and placed in self-contained classes." Haydt, Greenspan & Argharkar, *supra*, at 363. Professionals came to realize that IQ tests "only provided a narrow measure of intellectual functioning related to academic tasks ... thus ignoring important aspects of intellectual functioning that included social and practical skills." AAIDD Manual 43–44.

Partly in response to these concerns, in 1961, the AAIDD published a diagnostic manual for intellectual disability that sought to deemphasize exclusive reliance on IQ.[4] See Stephen Greenspan & Harvey N. Switzky, *Forty-four Years of AAMR Manuals*, in WHAT IS MENTAL RETARDATION?: IDEAS FOR AN EVOLVING DISABILITY IN THE 21ST CENTURY 3-28 (Harvey N. Switzky ed., 2006). The 1961 AAIDD manual began with a *conceptual* definition of intellectual disability as "subaverage general intellectual functioning which originates during the developmental period and is as-

[4] The AAIDD was formerly known as the American Association on Mental Deficiency (AAMD) and later the American Association on Mental Retardation (AAMR). For the sake of consistency, it is referred to throughout this brief as the AAIDD wherever possible.

sociated with impairment in adaptive behavior." *Id.* at 5. The major components of that conceptual definition have remained, in more or less that form, ever since.

But the conceptual definition begat certain crucial implementation questions. First, how is "subaverage general intellectual functioning" assessed? Second, what is the meaning and relative importance of "impairment in adaptive behavior?" As to the first, the 1961 manual defined "subaverage" as performance on a "measure[] of general intellectual functioning"—an IQ test—that is "greater than one Standard Deviation below the population mean of the age group involved." *Ibid.* (That would mean an IQ score of 84 or less. *Ibid.*) As to the latter, the manual defined "adaptive functioning" (somewhat vaguely) as the "effectiveness of the individual in adapting to the natural and social demands of his environment," as reflected in "limitations" in "maturation," "learning," or "social adjustment for different age groups." *Id.* at 5–6.

The aim of the 1961 AAIDD manual was that approximately seventeen percent of the population would fall below the IQ threshold, and the adaptive-behavior prong of the test would further narrow the population to a prevalence of around "three percent"—the conventional wisdom being that intellectual disability "was an appropriate diagnosis for the least intelligent three percent of the population." Haydt, Greenspan & Argharkar, *supra*, at 364. Unfortunately, in practice, "practitioners and agencies" essentially "ignored" the adaptive-behavior prong and continued to focus exclusively on IQ. *Ibid.*; see also Greenspan & Switzky, *supra*, at 8 (chief "perceived

problem[]" with the 1961 manual was "its creation of a Borderline category with an IQ ceiling of 85," which was "exacerbated by diagnosticians' widespread ignoring of the Adaptive Behavior criterion").

In an attempt to solve that problem, the AAIDD's 1973 manual—while essentially leaving in place the conceptual definition of intellectual disability—made certain operational changes. The required IQ score was changed from "minus one standard deviation ... to minus two standard deviations" (a score of 70 on the standard scale). Greenspan & Switzky, *supra*, at 9. In the hope that this would prompt more clinical attention on adaptive deficits, the 1973 manual also elaborated further on the definition of "adaptive behavior," explaining that it was defined by an individual's ability to "meet[] the standards of personal independence and social responsibility expected of his age and cultural group," and gave various examples. *Id.* at 9. When the American Psychiatric Association released the Third Edition of its Diagnostic and Statistical Manual (the "DSM-III") in 1980, it largely tracked this 1973 AAIDD manual—replacing a definition in the DSM-II that was widely regarded as inappropriate. See Haydt, Greenspan & Argharkar, *supra*, at 363 (DSM-III "followed the lead pretty closely of the most recent AAIDD manual").

Both the DSM and the AAIDD manuals also came to grapple with a basic statistical problem in how some diagnosticians were using IQ scores: the concept of standard measurement error (or SEM). SEM represents the variation around the "true score"—one that would be obtained if the test were perfectly reliable—and yields a statistical confidence interval (typically ±5 points). See AAIDD Manual 36. The

general concept is equivalent to the margin of error in a poll, such that a full scale IQ "score of 70 is most accurately understood not as a precise score but as a range of confidence," with a 95% confidence that the true answer lies within 2 SEM of the individual's score. AAIDD Manual 224. Clinical judgment must therefore be brought to bear on an IQ score along with other indicia of intellectual functioning in order to create an appropriate diagnosis.

B. The Diagnostic Criteria in Effect at the Time of *Atkins*

In 2002, this Court decided *Atkins v. Virginia*, which held for the first time that the execution of an intellectually disabled prisoner was unconstitutional. 536 U.S. 304 (2002). The Court's opinion invoked the AAIDD's (then still the AAMR) 1992 manual as well as the "similar" definition in the revised fourth edition of the DSM, the DSM-IV-TR.[5] *Id.* at 308 n.3 (quoting American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 39 (4th ed. 2000) (herein "DSM-IV-TR")). Those standards tracked the conceptual definition that had been largely stable since the 1961 AAIDD manual: a diagnosis required "significantly subaverage intellectual functioning," accompanied by "limitations" in adaptive functioning in various further-enumerated skill areas (such as "communication," "self-care," and "functional academic skills"), with onset in the devel-

[5] The DSM-IV was released in 1994; the DSM-IV-TR, in 2000, was a technical revision that left the diagnostic categories and the vast majority of the specific criteria for diagnosis unchanged.

opmental period. *Ibid.* Under then-prevailing norms, this typically meant "an IQ level of 50–55 to approximately 70." *Ibid.*

The *Atkins* Court acknowledged that there might be "serious disagreement" about "which offenders are in fact [intellectually disabled]." *Id.* at 317. "Not all people who claim to be" will in fact "be so impaired as to fall within the range of ... offenders about whom there is a national consensus," this Court reasoned. *Ibid.* But while noting that the task "of developing appropriate ways to enforce the constitutional restriction" would be left "to the States," this Court nonetheless observed that States' various "statutory definitions ... generally conform to the clinical definitions" reviewed earlier in the opinion. *Ibid.* & n.22 (quoting *Ford v. Wainwright*, 477 U.S. 399 (1986)).

Following the Court's decision in *Atkins*, courts across the country were required (in many cases for the first time) to determine whether a prisoner was intellectually disabled and thus ineligible for execution. In so doing, the "most cited technical reference in *Atkins* cases" quickly became the then-current DSM-IV-TR. Haydt, Greenspan & Argharkar, *supra*, at 368. The Court's citation of the DSM-IV-TR (along with the related AAIDD manual) certainly made this a reasonable choice—and there is no indication that anyone thought that older versions of the APA's manuals should be used, such as the DSM-II or the DSM-III.

Unfortunately, courts almost immediately seized upon the DSM-IV-TR's definition of a person with "significantly subaverage general intellectual functioning" as being defined "by the [IQ] obtained by as-

sessment with one or more" standardized intelligence tests, resulting in "an IQ of about 70 or below." DSM-IV-TR 39. The result was "an evidentiary free-for-all" as courts and counsel "were overwhelmed by basic statistical concepts of error of measurement, test norming, test validity and reliability." Haydt, Greenspan & Argharkar, *supra*, at 369. Assessments of "adaptive functioning" were in many cases "thrown by the wayside," because the DSM-IV-TR "had no ... standardized measurements of adaptive functioning," such that the "connection between adaptive functioning and intellectual functioning was lost in the shadow of IQ." *Ibid.*

In *Ex parte Perkins*, for example, the first Alabama case in the wake of *Atkins*, the Alabama Supreme Court relied on the DSM-IV as being the "most common definitions" of intellectual disability. 851 So. 2d 453, 457 (Ala. 2002). The Alabama Court denied relief, stating that the defendant "has a full-score IQ of 76," and thus did not have "significantly subaverage intellectual functioning (an IQ of 70 or below)." *Ibid.* The Alabama court did not engage in any meaningful discussion of "adaptive function or age of onset." Haydt, Greenspan & Argharkar, *supra*, at 379. Nor did the *Perkins* court engage meaningfully with SEM. See also *Engram v. State*, 200 S.W. 3d 367 (Ark. 2004); *Anderson v. State*, 163 S.W. 3d 333 (Ark. 2004); *Murphy v. State*, 54 P.3d 556 (Okla. Crim. App. 2002) (relying on the DSM-IV-TR and committing similar errors).

C. The Modern Standards in the DSM-5, As Applied in *Hall*

The fifth edition of the DSM, published in 2014, was the result of a "massive undertaking that involved hundreds of people working toward a common goal over a 12-year process." DSM-5 5. And the DSM-5 emerged (along with the essentially contemporaneous AAIDD Manual) at a time of widespread confusion among the courts on how to apply the *Atkins* standard. The new standards made certain crucial changes in the diagnosis of intellectual disability, designed to correct excessive reliance on raw IQ at the expense of nuanced intelligence assessment and clinical analysis of adaptive functioning. In that respect, the DSM-5 represents the "culmination of efforts to reduce reliance on IQ." Haydt, Greenspan & Argharkar, *supra*, at 365. One intent of the revisions was to ensure that individuals with developmental brain-based disorders could be diagnosed appropriately as intellectually disabled, even when an individual's IQ scores fall "above artificially-set IQ ceiling scores." *Id.* at 366.

The DSM-5's conceptual definition of intellectual disability is not radically changed. It is described as having "three criteria" that must be met: (1) deficits "in intellectual functions" (such as "reasoning" or "problem solving"), which are "confirmed by *both* clinical assessment *and* individualized, standardized intelligence testing"; (2) deficits in "adaptive functioning," such that an individual has limited functioning "in one or more activities of daily life, such as communication, social participation, and independent living"; and (3) onset of these deficits "during the developmental period." DSM-5 33 (emphasis added). On its

own, that bears a reasonably high similarity to the conceptual definition that had been in use since 1961.[6]

But while there is thus "overlap" between the DSM-5 definition of intellectual disability and previous definitions, there are also "significant differences" in how the idea is operationalized. Haydt, Greenspan & Argharkar, *supra*, at 379. First, and most crucially, the DSM-5 expressly states that diagnosis of intellectual disability should be "based on *both* clinical assessment *and* standardized testing of intellectual *and adaptive* functions"—such that exclusive reliance on IQ tests (which are not, standing alone, "clinical assessments," and which do not purport to measure adaptive function) is inappropriate. DSM-5 37 (emphasis added).

Moreover, the DSM-5 is the first diagnostic manual to classify the severity in intellectual disability according to assessments of adaptive functioning rather than an IQ score. DSM-5 33–36. That is because "it is adaptive functioning," "not IQ scores," that "deter-

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[6] But, as four members of this Court have observed, even this conceptual definition represents significant evolution between the DSM-IV-TR and DSM-5. In his *Hall* dissent, Justice Alito (joined by three other members of the Court) observed (without contradiction) that the DSM-5 "fundamentally alters the first prong of the longstanding, two-pronged definition of intellectual disability" by discarding "'significantly subaverage intellectual functioning' as an element of the intellectual-disability test." 134 S. Ct., at 2006 (Alito, J., dissenting). And that is true: the DSM-5 now requires only "deficits in intellectual functions" that are "confirmed by both clinical assessment and individualized, standardized intelligence testing." DSM-5 33.

mines the levels of supports required"—such that deficits in adaptive functioning have far greater practical significance. *Id.* at 33. The DSM-5 recognizes that IQ scores "are approximations of conceptual functioning," but may be "insufficient to assess reasoning in real-life situations and mastery of practical tasks." DSM-5 37. A person with "an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score." *Ibid.*

The DSM-5 also officially recognized, for the first time, the phenomenon of test norm obsolescence—"overly high scores due to out-of-date test norms." DSM-5 37. Because an IQ test is a normed test, and population norms change over time (for various reasons), if aging test norms are not taken into account, it is well-established that "average scores on an IQ test" will appear to "artificially increase over time."[7] ABA Report, EVALUATING FAIRNESS AND ACCURACY IN STATE DEATH PENALTY SYSTEMS 392 (2013). That is, the *very same* person taking a given IQ test will score lower than he would if he took a test that was normed further in the past. Thus, a statistical adjustment is required "as time passes from the specific point in time when the publisher standardized the

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[7] This is sometimes known as the "Flynn effect." See generally James R. Flynn, WHAT IS INTELLIGENCE?: BEYOND THE FLYNN EFFECT (2007); Frank M. Gresham & Daniel J. Reschly, *Standard of Practice and Flynn Effect Testimony in Death Penalty Cases*, 49 Intellectual & Developmental Disabilities 131, 134–37 (2011).

test." Geraldine W. Young, Note, *A More Intelligent and Just Atkins: Adjusting for the Flynn Effect in Capital Determinations of Mental Retardation or Intellectual Disability*, 65 Vand. L. Rev. 615, 617 (2012).

In *Hall*, this Court applied the DSM-5 standards to invalidate Florida's procedures for addressing *Atkins* claims. This Court reasoned that society "relies upon medical and professional expertise to define and explain how to diagnose the mental condition at issue," such that in "determining who qualifies as intellectually disabled, it is proper to consult the medical community's opinions." 134 S. Ct., at 1993. The Court concluded that the Florida rule at issue "disregards established medical practice" in two ways: by taking "an IQ score as final and conclusive evidence of a defendant's intellectual capacity," when the DSM-5 directs consideration of "other evidence," and (relatedly) by relying "on a purportedly scientific measurement of the defendant's abilities, his IQ score, while refusing to recognize that the score is, on its own terms, imprecise." *Id.* at 1995 (discussing measurement error).

In sum, as a fact sheet published in advance of the DSM-5 put it, the new standard "emphasizes the need to use both clinical assessment and standardized testing of intelligence when diagnosing intellectual disability, with the severity of impairment based on adaptive functioning rather than IQ test scores alone." American Psychiatric Association, DSM-5 INTELLECTUAL DISABILITY FACT SHEET (2013), available at http://goo.gl/Sus8VO. By "removing IQ test scores from the diagnostic criteria, but still including them in the text description of intellectual disability, DSM-5 ensures that they are not overemphasized as the

defining factor of a person's overall ability, without adequately considering functioning levels." *Ibid.*

II. MODERN CLINICAL STANDARDS WILL MAKE A LIFE-OR-DEATH DIFFERENCE FOR MANY PRISONERS

As demonstrated above, the criteria for intellectual disability have evolved significantly, to progressively (1) reduce mechanical emphasis on IQ scores, (2) take account of SEM and test-norm obsolescence when such scores *are* used, and (3) increase primary reliance on individualized clinical assessment of intellectual and adaptive deficits. These changes in criteria are of incredible practical importance, and will make a life-or-death difference in a significant number of cases—changing the outcome such that a prisoner who could be executed under the old standards could not be under the new.

A few examples are given below.

A. Bobby James Moore

The decision in this very case is an instance of modern standards being outcome-determinative. The trial judge, following a two-day evidentiary hearing, concluded that Moore was intellectually disabled under the criteria in the DSM-5 and the most current AAIDD manual. Pet. App. 4a. The trial court reached this conclusion in part based on its application of SEM and norm obsolescence to Moore's IQ scores, in line with the AAIDD manual "best practice[s]." Pet. App. 157a. In doing so, the trial court noted that it "join[ed] with the inventors of IQ tests ... in recognizing that IQ tests are not designed to—nor are they able to—produce a single and precise figure." Pet.

App. 155a. Under modern standards, all of this was correct.

But the Texas Court of Criminal Appeals concluded that the judge had "erred by ... employing the definition of intellectual disability presently used" by the leading mental-health organizations. Pet. App. 6a. While acknowledging that "the AAIDD's and APA's positions regarding the diagnosis of intellectual disability have changed," the Texas Court of Criminal Appeals nonetheless concluded that modern diagnostic criteria "do not determine whether an individual is exempt from execution under *Atkins*." Pet. App. 6a–7a.

The court then went on to rely essentially exclusively on IQ scoring while rejecting adjustments to those scores based on test-norm obsolescence. Pet. App. 7a–8a, 63a–75a. The court, relying mechanically on IQ scores, concluded that Moore "failed to prove ... that he has significantly sub-average general intellectual functioning" based on his IQ score of 78 obtained in 1973, and an IQ score of 74 obtained in 1989. Pet. App. 63a. At trial, Moore had presented evidence from his medical expert that the 78 IQ score should be adjusted to 70 to account for norm obsolescence, and that his score of 74 should be adjusted to 71 for the same reason. Pet. App. 65a. Nonetheless, based on its recent holding that the "test score ... may not be changed" to account for test-norm obsolescence, the court denied relief. Pet. App. 73a-75a.

Under modern diagnostic criteria, this sort of exclusive emphasis on raw IQ scores would be improper, as would the failure to adjust the raw IQ scores in ways now recognized as clinically required. It is un-

surprising, therefore, that the trial court in this case (which used modern diagnostic criteria) granted relief, and the court below did not.

B. Isaac Creed Agee

Another particularly vivid example of the difference that modern clinical standards can make is the case of Isaac Creed Agee. See *State v. Agee*, 358 Or. 325 (2015) (en banc) (slip op.). At his 2011 murder trial, Agee argued that he was intellectually disabled and therefore ineligible for the death penalty. *Id.* at 2. The trial court found that Agee "suffered from partial fetal alcohol syndrome," but that he "had not established an intellectual disability that would make him constitutionally ineligible for the death penalty." *Ibid.*

In so doing, the trial court evaluated "the severity" of Agee's intellectual disability "by [his] IQ score." *Id.* at 9. Agee had relatively high IQ scores, and so while the trial court did not apply a "rigid cutoff," it did conclude that his scores overall were "too high to permit a finding ... of 'significantly subaverage intellectual functioning,'" as then-current diagnostic criteria required. *Id.* at 12. The Oregon Supreme Court concluded that this "ruling was not erroneous at the time it was made." *Ibid.*

Nonetheless, the *Agee* court reversed, accepting the defendant's argument that the modern standards as reflected in the DSM-5—which departed "from a rigid reliance on IQ test scores"—required a "new evidentiary hearing in light of current scientific knowledge, so that the trial court can make a determination of intellectual disability under a proper understanding of prevailing medical practice." *Id.* at 13. The court observed that the DSM-5 "deletes reference

to particular IQ scores, emphasizing instead that clinical assessment and standardized test results confirm a person's deficits in intellectual functions." *Id.* at 14. And it quoted with approval Justice Alito's statement that the DSM-5 "fundamentally alters the first prong of the longstanding, two-pronged definition of intellectual disability," and "discards 'significantly subaverage intellectual functioning' as an element of the intellectual-disability test." *Id.* at 14 (quoting *Hall*, 134 S. Ct., at 2006 (Alito, J., dissenting)).

Thus, although accepting that the trial court's assessment may have "comported with the published standards existing at the time that the court ruled," the *Agee* court concluded that "now-current medical standards" may have made a material difference in determining whether the defendant had met "his burden of proof to show that he has an intellectual disability," and therefore "remand[ed] for a new *Atkins* hearing, in which the trial court shall consider the evidence presented in light of the standards set out in the DSM–5." *Id.* at 16–17.

C. Stephen Anthony Butler

Butler was convicted in a 1986 robbery-murder and sentenced to death. *Butler v. Quarterman*, 576 F. Supp. 2d 805 (S.D. Tex. 2008), *vacated in part on other grounds*, 2015 WL 5235206 (5th Cir. Sept. 9, 2015). His *Atkins* claim went to trial in 2007 Testimony at the hearing established that Butler had a poor academic history, was labeled "educable mentally retarded," and had speech skills consistent with intellectual disability. *Id.* at 810–12. Moreover, Butler presented evidence through medical experts that "the

state court's failure to find that he suffered from significantly sub-average intellectual functioning before the age of 18 [was] based on the state court's failure" to account for norm obsolescence in evaluating his IQ test scores. *Id.* at 813.

But the state's expert testified that (1) to the extent Butler had low IQ scores, they were because of poor education; (2) to the extent Butler had IQ scores that were old, norm obsolescence should not be taken into account; (3) Butler had no deficits in adaptive functioning because he was able to tell time, maintain his hygiene, and engage in recreational activities; and (4) Butler's extreme communication deficits were the result of severe mental illness, not intellectual disability. *Id.* at 813–27. On these bases, the court concluded that "Butler has not shown by clear and convincing evidence that the state court's findings are incorrect" and therefore denied relief. *Id.* at 816.

Direction from the DSM-5 "could have grounded expert testimony in current scientific thinking, which could have affected the outcome of the [*Butler*] case." Haydt, Greenspan, & Argharkar, *supra*, at 380. "For example, and in direct contradiction to the state expert's testimony," the DSM-5 describes those with mild intellectual disability as potentially able to function "age-appropriately in personal care," as well as having "recreational skills" that "resemble those of age-mates." *Ibid.* Moreover, co-occurring mental illness is "frequent" in intellectual disability. *Ibid.* The use of modern diagnostic criteria could thus have altered the outcome of Butler's case.

D. Paul Hardy and Victor Wayne Hooks

In *United States v. Hardy*, 762 F. Supp. 2d 849, 857 (E.D. La. 2010), the Court considered whether an individual was eligible for the death penalty when he received an IQ score of 73 on a 1996 examination. Under the DSM-IV's criteria for intellectual disability, which defined "[s]ignificantly subaverage intellectual functioning ... as an IQ of about 70 or below," a score of 73 would result in a standard of error range of 68-78, and therefore would be largely above the DSM-IV-TR's floor. DSM-IV 39.

When accounting for norm obsolescence, however, the Court recognized that his IQ "score of 73 is in fact a score of 67.06," rendering Hardy's full IQ score "somewhere between 62.06 and 72.06," and therefore largely within the range recognized in *Atkins*. 762 F. Supp. 2d at 866. Thus, while Hardy might (at best) have been a borderline case without any adjustment, accounting for norm obsolescence clearly established that he possessed an IQ score that demonstrated deficits in intellectual functionality—even when placing heavy reliance on IQ scores alone (which today's diagnostic criteria would not).

By contrast, in *Hooks v. Workman*, 689 F.3d 1148 (10th Cir. 2012), the prisoner had similar scores to the petitioner in *Hardy*, but the scores were *not* adjusted for obsolete norms, as the DSM-5 would require—and the prisoner was consequently deemed eligible for the death penalty. Hooks had received an IQ score of 72 in 1994, and an IQ score of 76 in 2002. *Id.* at 1168. The Tenth Circuit concluded that the State court's failure to take norm obsolescence into account did not constitute a violation of *Atkins*. *Id.* at

1170. Because Hooks' unadjusted scores (72 to 76) fell "into a 'gray area,'" the Tenth Circuit concluded that a "rational trier of fact [could] conclude from this evidence that [Hooks] indeed functions at a sub-average intellectual level, but it could also rationally draw the conclusion that he does not." *Id.* at 1171.

Hardy was also specifically disapproved by the Texas courts in *Ex parte Cathey*, 451 S.W. 3d 1, 15 n.43 (Tex. Crim. App. 2014)—which, in turn, led the court below to deny relief to the petitioner here. That further illustrates both the division in authority on the question presented and the life-or-death difference it can make to a condemned prisoner.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for a writ of certiorari.

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